# PERMISSION FOR RELEASE OF INFORMATION

**NAME: _____**
(print)

I give my permission for the following agencies or departments to share information contained in my assessment and case record. I agree that _____ can share
(Agency Completing Assessment)
information with the agencies and departments which I have checked below. I understand that all information will be respected as confidential by these agencies or departments and that it will be used solely to facilitate receiving services.

_____ Home Health Agency
_____ Adult Day Service
_____ Medicaid Waiver Team
_____ Area Agency on Aging
_____ Residential Care Home
_____ Physician
_____ Mental Health Agency
_____ HASS
_____ Department for Children and Families
_____ Other(s)

Specify Others:_____

Individualized Instructions: _____

_____

I understand that the Independent Living Assessment will be shared with the Department of Disabilities, Aging and Independent Living for the purpose of eligibility determination, program monitoring, research and planning. I have read this **RELEASE OF INFORMATION,** and I agree to its terms as stated or amended. I understand that I may, at any time, revoke my consent to share any or all of the information on this assessment by calling or writing the agency listed below.

_____

Agency Agency Phone

Client/Guardian Signature: _____

Signature of person explaining consent: _____

_____

Job Title/Position Agency Date

**Consent to share this information expires on _____(no more than one year)**
**date**

***A copy of this form must be provided to all signatories***

DAIL 05/05